# PLEASE RETURN THIS FORM TO EBD ONLY

**STATE OF ARKANSAS**
**Department of Finance and Administration**

**EBD**
**Employee Benefits Division**
**Post Office Box 15610**
**Little Rock, Arkansas 72231-5610**

**Phone: (501) 682-9656** **Toll Free: (877) 815-1017** **Fax: (501) 683-0983** **www.ARBenefits.org**

## Student Verification Form

Subscriber's Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

To continue coverage, eligible dependents over the maximum dependent age according to the group's contract (19), must be enrolled as a full-time student at an accredited educational institution, and must have the same permanent residence as the primary Subscriber. Student dependents may remain on the Subscriber's plan until the end of the month in which they turn 24, as long as they maintain full-time student status. The Employee Benefits Division verifies eligibility once a year. This form may be used to update student status at any time. **Failure to provide complete and accurate information may result in cancellation of coverage by the Employee Benefits Division. This form must be returned to EBD once a year for coverage to continue.**

If a student is **no longer** eligible for coverage as a dependent, he/she may be eligible for continuation of coverage under federal and state COBRA guidelines.

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Dependent's Name: _____

Date of Birth: _____ Dependent's 8-digit Member #: _____

Semester: ❒ Spring ❒ Fall Year: _____

❑ Dependent is not a full-time student.

_____
(Date dependent was or will no longer be a student.)

❑ Dependent is a full-time student at an accredited institution.

_____
(Name of accredited institution. No documentation from institution is required.)

_____
(City) (State) (Zip) (Phone)

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**I declare that all statements on this form are complete and true and I understand that they are the basis on which insurance may be maintained under this group plan.**

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Subscriber's Signature: _____ Date: _____

**Note: If coverage needs to continue for other reasons, contact EBD.**